detoxification programs, fewer than 3% have subsequently required admission to hospital. But some withdrawal-related conditions require benzodiazepine sedation in a hospital. Mixed alcohol-drug abuse, a past history of withdrawal seizures or delirium tremens, either a pulse rate or Fahrenheit temperature about 100, or the presence of serious intercurrent illness mandates hospital admission. Rather large doses of chlordiazepoxide or diazepam normalize these patients' nighttime sleep and vital signs, while reducing morbidity and mortality.

Although benzodiazepines control acute abstinence syndromes, these drugs do not improve long-term outcome of excessive drinkers; relapse rates are similar in groups chronically treated with benzodiazepines or placebos. Thus, benzodiazepines are used in hospital for two to five days to suppress abstinence syndromes, but are rarely prescribed to outpatient alcoholic patients, who tend to abuse these drugs.

Among hospital patients, steps 1 through 5 above need not be deferred until the abstinence syndrome is fully controlled. A vomiting patient with malaise and insomnia may be highly motivated to stop drinking; comfortable and awaiting discharge several days later, he or she may be much less motivated. Detailed history-taking, building an alliance, involving the family and arranging a visit from an AA member can all occur with the patient ill and in hospital; long-term treatment for the drinking problem can be initiated well before detoxification is completed.

Conclusions

Alcoholism is common, is treatable and has a favorable prognosis. Physicians can reliably identify and evaluate covert cases, providing needed referral or treatment. But alcoholism may have a chronic course with remissions and relapses; many patients will have recurring episodes. Realistically recognizing this course, physicians may reduce the frequency and severity of relapses, while promoting and sustaining remissions, with the protocol outlined here.

GENERAL REFERENCES

Bean MH: Denial and the psychological complications of alcoholism, *In* Bean MH, Zinberg NE (Eds): Dynamic Approaches to the Understanding and Treatment of Alcoholism. New York, Free Press, 1981, pp 55-96

Bernadt MW, Mumford J, Taylor C, et al: Comparison of questionnaire and laboratory tests in the detection of excessive drinking and alcoholism. Lancet 1982 Feb 6; 1:325-328

Crowley TJ, Rhine MW: Abuse of alcohol and other drugs, *In* Simons RC, Pardes H (Eds): Understanding Human Behavior in Health and Illness, 2nd Ed. Baltimore, Williams & Wilkins, 1981, pp 657-670

Miller WR, Munoz RF: How to Control Your Drinking, 2nd Ed. Albuquerque, University of New Mexico Press, 1982

Senay EC: Substance Abuse Disorders in Clinical Practice. Boston, John Wright-PSG Inc, 1983

Medical Practice Questions

EDITOR'S NOTE: *From time to time medical practice questions from organizations with a legitimate interest in the information are referred to the Scientific Board by the Quality Care Review Commission of the California Medical Association. The opinions offered are based on training, experience and literature reviewed by specialists. These opinions are, however, informational only and should not be interpreted as directives, instructions or policy statements.*

Assistant Surgeon for Septorhinoplasty

QUESTION:

Is it necessary to use an assistant surgeon in the performance of a septorhinoplasty?

OPINION:

In the opinion of the Scientific Advisory Panels on Otolaryngology/Head and Neck Surgery and Plastic Surgery, it is not accepted medical practice to use an assistant surgeon in the performance of a septorhinoplasty.